Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1385

DATE: May 8, 2014

TO: Iowa Medicaid Health Home Providers, Targeted Case Managers (TCM), Case Managers (CM), and Department of Human Services (DHS) Service Workers (SW)

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Required Collaboration between Chronic Health Homes and TCM/CM/SWs

EFFECTIVE: Upon Receipt

Health Home, also known as a medical home, is a Medicaid program that supports qualified Medicaid providers by offering Health Home services for members with specific chronic conditions. The program enrolls provider organizations within primary care that are capable of delivering personal, coordinated care activity and enhanced patient support to drive improved outcomes for members meeting Health Home eligibility requirements.

A member eligible for the Health Home program, and who is on a waiver with TCM/CM/SW services, will retain both the Health Home and TCM/CM/SW services. This letter is to define the roles and responsibilities of Health Homes, TCM/CM/SWs working with individuals with specific chronic conditions.

This letter does not refer to the role of an Integrated Health Home (IHH). An IHH focuses on individuals with a serious and persistent mental illness (SPMI) or serious emotional disturbance (SED).

Health Home Services

The Health Home is the hub of a patient's care to prevent gaps or duplication of services. Networking with services provided outside the clinic is essential for success in these efforts. A Release of Information will need to be obtained from the member for the Health Home to communicate with TCM/CM/SWs and service providers. A Health Home is required to provide the Health Home services listed below:

HealthHomeServices

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services

- Referral to Community and Social Support Services

Iowa Administrative Code 441, chapter 77.47(1)c requires a Health Home to collaborate with TCM/CM/SWs at least quarterly for each enrolled member also receiving case management services. Strategies to prevent duplication of care coordination efforts by the Health Home and TCM/CM/SWs must be developed by the Health Home and documented in the member's file. Documentation of the collaboration may include, but is not limited to, records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated. Documentation of care coordination duplication efforts must be presented by the Health Home to the department upon request.

Case management is a method to manage multiple resources effectively for the benefit of special populations of Medicaid members. The service is designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. Case management functions include:

- Comprehensive assessment and periodic reassessment of the member's individual needs.
- Development and periodic revision of a comprehensive service plan based on the comprehensive assessment, including a crisis intervention plan.
- Activities to help the member obtain needed services, such as scheduling appointments and activities that help link the member to service providers.
- Activities and contacts necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member.
- At least one face-to-face contact with the member every three months and at least one contact per month on behalf of the member.

Collaboration between a Health Home and the TCM/CM/SW may be initiated by the Health Home or by the TCM/CM/SW. While there is no IME formalized process for this collaboration, the Health Home must make contact at least quarterly, as noted above. During the collaboration, the Health Home and the TCM/CM/SW are expected to share all relevant information regarding the member's situation and needs. The end product of the collaboration would be an understanding of the needs of the member and division of responsibilities so there is no duplication of service between the Health Home and the TCM/CM/SW.

Providers interested in offering Health Home services can visit the IME Health Homes for Providers[1] webpage or may contact Pamela Lester at plester@dhs.state.ia.us for additional information.

[1] http://www.ime.state.ia.us/Providers/healthhome.html